# *State of Idaho Emergency Medical Services Bureau*
## *Provider Application Form*

**Level Applied For:** ☐ First Responder ☐ EMT-Basic ☐ Advanced EMT-A ($35.00 fee) ☐ EMT-Paramedic ($35.00 fee)

**Type:** ☐ Initial ☐ Recertification ($25.00 fee for AEMT-A and EMT-P) ☐ Reinstatement ☐ Reversion ☐ Ambulance Rating (complete back) ☐ Reciprocity

### Applicant Information:

Social Security # ____ - ____ - ____ Date of Birth ____ / ____ / ____ Drivers License # _____ DL State ____

Name _____ Gender ☐ F ☐ M

Last Name First Name Middle Name/Initial

Mailing Address _____

City _____ State _____ Zip _____ County _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

E-Mail Address _____ Circle the highest level of education: GED High School Diploma College: 1 2 3 4 5 6 7 8

### Affiliation:

Agency Name _____ Agency License # _____

Agency Chief/Director/President _____ _____

**Signature** Printed Name

Additional Licensed EMS Affiliations: _____

Check all circumstances in which you will use this certification: *Volunteer* *Career*

☐ True ☐ Full Time

☐ Compensated ☐ Part Time

### Applicant Signature:

I hereby affirm the information herein is true and correct, and that I meet all requirements for EMS certification as established by the State of Idaho.

_____ _____

**Signature of Applicant** Date signed

**For Bureau Use Only**

Received in RO Complete

Received in CO Complete

CHC Scan Date (PROV) _____

CHC Complete Date (FULL) _____

Course # _____

NR Written Date _____

NR Practical Date _____

Ambulance Rating ( if AEMTA)

Date _____ Included ☐

Cert. Fee Rcvd Date_____

Approval Date/Initial _____

Entered into Database _____

_____

Date Sent to CO _____

Previous ID State Certification ☐ _____

First Responder/Basic

| Test Date | Expiration |
|---|---|
| 4/03-9/03 | 9/30/2006 |
| 10/03-3/04 | 3/31/2007 |
| 4/04-9/04 | 9/30/2007 |
| 10/04-3/05 | 3/31/2008 |
| 4/05-9/05 | 9/30/2008 |
| 10/05-3/06 | 3/31/2009 |
| 4/06-9/06 | 9/30/3009 |
| 10/06-3/07 | 3/31/2010 |
| 4/07-9/07 | 9/30/2010 |
| 10/07-3/08 | 3/31/2011 |
| 4/08-9/08 | 9/30/2011 |

Advanced, Intermediate and Paramedic

| Test Date | Expiration |
|---|---|
| 4/04-9/04 | 9/30/2006 |
| 10/04-3/05 | 3/31/2007 |
| 4/05-9/05 | 9/30/2007 |
| 10/05-3/06 | 3/31/2008 |
| 4/06-9/06 | 9/30/2008 |
| 10/06-3/07 | 3/31/2009 |
| 4/07-9/07 | 9/30/2009 |
| 10/07-3/08 | 3/31/2010 |
| 4/08-9/08 | 9/30/2010 |

## ADVANCED EMT-A

☐ **$25 Advanced EMT-A recertification fee**

## Recertification Education Record

**Applicant Name**:_____

All recertification requirements must be complete and submitted between the effective date and the expiration date of the current certification. Recertification requires an EMS Bureau approved EMT-Basic Refresher, an EMS Bureau approved Advanced EMT-A Refresher Course, 24 hours of continuing education and verification of skills.

AEMT-A Refresher Course #_____Completion Date _____ Instructor:_____

EMT-Basic Refresher Options (Complete 1) - Attach proof of completion

- ☐ Traditional EMS Bureau approved Refresher #_____ Completion Date_____ Instructor _____
- ☐ CECEBEMS Approved Refresher Education Online Vendor _____Completion Date_____
- ☐ After 12/31/06 successfully pass the EMT-B NREMT computer adaptive test at a Pearson Vue testing center. Date Complete_____
- ☐ Agency Sponsored Ongoing Training Education Plan (OTEP) approved by the EMS Bureau

### Continuing Education

| Course Topic | Instructor | Date | Hours | Course Topic | Instructor | Date | Hours |
|---|---|---|---|---|---|---|---|
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| **Total** | | | | **Total** | | | |

### Skills Proficiency

| | |
|---|---|
| Trauma and Medical Patient Assessment and Management | Assisted Medication Administration |
| Cardiac Arrest and CPR/AED skills | Childbirth Skills to include care of the newborn |
| Basic Ventilatory management and oxygen administration to include upper airway adjuncts, suction and bag-valve-mask | Spinal Immobilization, both seated and supine including application of cervical collar |
| Advanced Airway Management | Hemorrhage Control/Shock Management |
| Intravenous Therapy | Splinting Procedures to include traction splinting |

As the Physician Medical Director for the above named EMS Agency, I attest to the competence of the applicant named on this form in all the *Assurance of Knowledge* and *Skills Proficiency* categories listed on this page and recommend recertification of this individual.

**Signature of the agency Medical Director** **Date** **Printed name of the agency Medical Director**

_____ _____ _____

Revised form 09/01/2006